Supreme Court, U.S.
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No. 93-865

In the Supreme Court of the United States

OCTOBER TERM, 1993

BLUE CROSS AND BLUE SHIELD OF ALABAMA,
PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether, under petitioner's Medicare supplemental health insurance (medigap) policies, petitioner may deny reimbursement to a Veterans Affairs hospital for medical services that are provided to Medicare-eligible patients, but for which the Medicare program does not provide reimbursement.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	9
Conclusion	15

TABLE OF AUTHORITIES

Cases:

Connolly v. *Pension Benefit Guaranty Corp.*, 475 U.S. 211 (1986)	9, 14
FHA v. *The Darlington, Inc.*, 358 U.S. 84 (1958)	14
Norman v. *Baltimore & O.R.R.*, 294 U.S. 240 (1935)	14
United States v. *Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718 (4th Cir.), cert. denied, 114 S. Ct. 302 (1993)	2, 7, 10, 11
United States v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993)	2, 8, 10, 12

Constitution, statutes, regulations, and rule:

U.S. Const. Amend. V	9, 10, 12
Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, Tit. XIX, 100 Stat. 372:	
§ 19013, 100 Stat. 382-385	3
§ 19013(b), 100 Stat. 385	13
Department of Veterans Affairs Codification Act, Pub. L. No. 102-83, § 5(a), 105 Stat. 406 (1991)	3
Social Security Disability Amendments of 1980 (Baucus Amendment), Pub. L. No. 96-265, § 507, 94 Stat. 476	5
Veterans' Benefits Act of 1957, 38 U.S.C. 1701 *et seq.*	2
38 U.S.C. 1710(a)(1)(I) (Supp. IV 1992)	2
38 U.S.C. 1729 (Supp. IV 1992)	2, 3, 6, 7, 9, 10, 12, 13, 14
38 U.S.C. 1729(a)(1) (Supp. IV 1992)	3, 7
38 U.S.C. 1729(b) (Supp. IV 1992)	4
38 U.S.C. 1729(f) (Supp. IV 1992)	3, 12

Statutes, regulations, and rule—Continued: Page

38 U.S.C. 1729(i)(1)(A) (Supp. IV 1992) 4, 6
38 U.S.C. 1729(i)(1)(B)(i) (Supp. IV 1992) 4
38 U.S.C. 1729(i)(3)(D) (Supp. IV 1992) 4
Veterans' Health Care, Training, and Small Business Loan Act of 1981, Pub. L. No. 97-72, Tit. I, § 106, 95 Stat. 1050-51 2
38 U.S.C. 629 2
42 U.S.C. 1395c 4
42 U.S.C. 1395e(a)(3) 5
42 U.S.C. 1395f(c) 4
42 U.S.C. 1395n(d) 4
42 U.S.C. 1395y(a)(2) 4
42 U.S.C. 1395ss 5
42 U.S.C. 1395ss(g)(1) 5
42 C.F.R. Pts. 409-410 4
Sup. Ct. R. 14.1(a) 10

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-10a) is reported at 999 F.2d 1542. The opinion of the district court (Pet. App. 11a-16a) is reported at 791 F. Supp. 288.

JURISDICTION

The judgment of the court of appeals was entered on September 8, 1993, and a petition for rehearing was denied on October 15, 1993. Pet. App. 17a. The petition for a writ of certiorari was filed on December 1, 1993. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. This case is the latest of a number of cases to reach the appellate courts in which a private health insurance carrier has refused to honor a request by the Department of Veterans Affairs (VA) for reimbursement of the costs of medical services that VA provided free of charge to Medicare-eligible veterans.[1] Under the Veterans' Benefits Act of 1957, 38 U.S.C. 1701 *et seq.*, a veteran may be furnished hospital care for a non-service-connected disability if the veteran is unable to defray the cost of such care. 38 U.S.C. 1710(a)(1)(I) (Supp. IV 1992). In 1981, Congress determined that VA, as a provider of medical services, should be entitled to recover the reasonable costs of caring for a veteran's non-service-connected disability in those situations in which the veteran would be eligible to receive compensation for such medical care from a third party if the care had not been provided by VA. Veterans' Health Care, Training, and Small Business Loan Act of 1981, Pub. L. No. 97-72, Tit. I, § 106, 95 Stat. 1050-1051 (codified as amended at 38 U.S.C. 1729 (Supp. IV 1992)). Section 1729 [2] was specifically amended in 1986 to give the

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[1] This Court recently denied certiorari in *United States* v. *Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718 (4th Cir.), cert. denied, 114 S. Ct. 302 (1993), where the Fourth Circuit held that a private insurer may not refuse to reimburse VA for costs that would otherwise be paid to a private hospital under the terms of the insurer's medigap policies. See also *United States* v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993) (same).

[2] The anti-discrimination provision was originally codified as 38 U.S.C. 629, but was amended and renumbered in 1991.

United States authority to pursue recovery from a veteran's medical insurer. Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, Tit. XIX, § 19013, 100 Stat. 382-385. Because its purpose is to put VA on an equal footing with all other providers of medical services, and thus to prohibit insurers from denying reimbursement to VA when reimbursement would otherwise be paid to private hospitals, Section 1729 has generally been referred to as the "anti-discrimination" statute.[3] Further, Section 1729 prevents the abrogation of the statute by state law or private contract by providing that no state law and "no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section." 38 U.S.C. 1729(f) (Supp. IV 1992).

The statute defines the third parties from which the United States may recover the costs of medical services to include States, employers, automobile insurance carriers, and persons "obligated to provide,

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See Department of Veterans Affairs Codification Act, Pub. L. No. 102-83, § 5(a), 105 Stat. 406 (1991).

[3] 38 U.S.C. 1729(a)(1) (Supp. IV 1992) provides:

> Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

or to pay the expenses of, health services under a health-plan contract." 38 U.S.C. 1729(i)(3)(D) (Supp. IV 1992). The term "health-plan contract" means "an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid." 38 U.S.C. 1729(i)(1)(A) (Supp. IV 1992). The United States may enforce its right to recover through intervention, subrogation, or a separate action against the third-party payer. 38 U.S.C. 1729(b) (Supp. IV 1992).

b. Medicare Part A is a program of medical insurance providing insurance coverage for hospital care and related hospital services for persons who are over 65 years of age and who are eligible for Social Security retirement benefits. 42 U.S.C. 1395c. The Medicare Act and its implementing regulations set forth the conditions and limitations on the coverage of listed services and items, and they specify limits on what may be considered the reimbursable reasonable charge for covered services and items. See 42 C.F.R. Pts. 409-410. There are certain circumstances under which Medicare will not pay claims even though a patient qualifies for benefits and the services the patient receives are covered under the Act and regulations. As is relevant in this case, Medicare reimbursement is denied: (1) when the health care provider is a federal department or agency, 42 U.S.C. 1395f(c), 1395n(d); and (2) when the patient is not obligated to pay for the services provided, 42 U.S.C. 1395y(a)(2). Congress also specifically excluded Medicare from the definition of "health-plan contract" under 38 U.S.C. 1729(i)(1)(B)(i) (Supp. IV 1992), there-

by preventing VA from billing Medicare for the medical services it provides to Medicare-eligible patients. Those exclusions prevent VA hospitals from receiving Medicare reimbursement for medical services provided to veterans for non-service-connected disabilities for which the veterans are not obligated to pay.

Medicare also does not fully cover certain health care services. Thus, a patient remains responsible for paying various deductibles and coinsurance amounts. See 42 U.S.C. 1395e(a)(3). Private insurers fill these gaps in coverage by offering Medicare supplemental or "medigap" policies. Congress amended the Social Security Act in 1980 specifically to define medigap policies. See Social Security Disability Amendments of 1980, Pub. L. No. 96-265, § 507, 94 Stat. 476 (the Baucus Amendment) (codified as amended at 42 U.S.C. 1395ss). Section 1395ss defines a medigap policy to include (42 U.S.C. 1395ss(g)(1)):

> a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter * * *.

2. Petitioner Blue Cross and Blue Shield of Alabama (BCBS) is a private health insurance carrier that issues medigap policies in Alabama. The United States submitted claims to petitioner for reimburse-

ment on behalf of eight veterans[4] who held medigap policies (also referred to by BCBS as "C Plus" policies) issued by petitioner, and who had received medical care at VA hospitals in Alabama. Petitioner denied the claims on the ground that its medigap policies covered only those medical expenses incurred in a manner that would also trigger Medicare reimbursement. Because VA was not entitled to receive Medicare payments, the insurer denied the government's claims. The United States then instituted this action to recover benefits under the veterans' BCBS medigap policies, arguing that the anti-discrimination provision of the Veterans' Benefits Act (38 U.S.C. 1729) prohibited petitioner from refusing to pay.

The district court granted summary judgment in favor of the United States. Pet. App. 11a-16a. The court rejected petitioner's argument that it was not obligated by the terms of its medigap policies to pay any portion of the claims submitted by VA because the care and services were rendered by a "non-participating hospital." *Id.* at 12a. The court stated that while VA hospitals do not participate in Medicare,[5] "it is obvious that the Blue Cross Medigap

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[4] The United States originally sought to recover for the cost of medical care provided to nine veterans. Upon learning that one of the veterans was covered under a medigap policy issued by a BCBS of another State, the United States amended its complaint to delete reference to that veteran. See Pet. App. 3a n.3.

[5] The court opined that the obvious reason for the Act's exclusion of Medicare from the definition of "health plan contract," 38 U.S.C. 1729(i)(1)(A) was because "Congress decided not to 'rob Peter to pay Paul.'" Pet. App. 14a.

policy is a health plan contract." *Id.* at 14a. The court pointed out that if the veterans had been provided care and services in a participating private general hospital, they would have been eligible to receive payment from petitioner for deductibles and coinsurance. *Ibid.* Thus, the court concluded, the United States is entitled to recover under 38 U.S.C. 1729(a)(1). That result, the court declared, "flows ineluctably from the anti-discrimination provisions of 38 U.S.C. § 1729(f)." Pet. App. 14a. Accordingly, the court entered a declaratory judgment that Section 1729 applies to Medigap policies, and that petitioner is required to reimburse VA "for a portion of the cost of medical care and services received by veterans with non-service-connected disabilities at VA medical facilities who hold Medigap contracts with BCBS." Pet. App. 16a.

3. The court of appeals affirmed. Pet. App. 1a-10a. It first rejected petitioner's contention that 38 U.S.C. 1729 does not apply to medigap policies because they are not "health-plan contracts" within the meaning of the statute. Adopting instead the Fourth Circuit's reasoning in *United States* v. *Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718, 727, cert. denied, 114 S. Ct. 302 (1993), the court below observed that "[a] health-plan contract need do only one of two things—provide health services or reimburse the expenses of such services." Pet. App. 6a. Here, the court concluded, petitioner's medigap policies "undoubtedly qualify as policies 'under which . . . the expenses of [health] services are paid.' 38 U.S.C. § 1729(i)(1)(A)." Pet. App. 6a. The court relied on both the language and the legislative history of Section 1729 in support of its conclusion that the "medigap

policies issued by Blue Cross are health-plan contracts governed by the reimbursement and anti-discrimination provisions of § 1729." Pet. App. 7a (citing *United States* v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993)).

The court of appeals also found no merit in petitioner's argument that the United States is prevented from seeking reimbursement because a condition precedent to recovery under the medigap policy—payment by Medicare—is statutorily precluded from occurring when the medical care is delivered by a VA hospital. Pet. App. 7a-9a. In this regard, the court noted that although the medigap policies do not explicitly discriminate against the United States, a "contractual provision that operates to prevent recovery by the United States * * * is prohibited by the statute even where the discrimination is not apparent from the face of the policy." *Id.* at 7a. In the court of appeals' view, petitioner's participating hospital provision in its medigap policies "clearly operates 'to prevent recovery or collection by the United States' in contravention of 38 U.S.C. §1729(f)." *Id.* at 8a. The court explained that "[i]n virtually all cases, because VA hospitals may not recover expenses from Medicare, 38 U.S.C. § 1729(i)(1)(A), the policies would prevent reimbursement to the United States." *Id.* at 7a-8a. On the other hand, Alabama's private general hospitals all participate in Medicare "and therefore virtually always qualify for recovery under the medigap policies." *Id.* at 8a. As a practical matter, then, "VA is denied recovery while private hospitals are not." *Ibid.* The court held that "[t]his result constitutes discrimination against the

United States in violation of 38 U.S.C. § 1729(f)." Pet. App. 9a.

Finally, the court rejected petitioner's argument that recovery by the United States would impair its Fifth Amendment right to contract. The court explained that "[t]he right to contract is not without bound," and that the "application of a regulatory statute that is otherwise valid may not be defeated by private contracts." Pet. App. 9a (citing *Connolly* v. *Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224 (1986)). The court noted that petitioner did not challenge Congress's power to enact the anti-discrimination provisions of Section 1729, and it concluded that petitioner "cannot enter into contracts which violate existing law, then claim that the enforcement of that law infringes upon its right to contract." Pet. App. 9a.

Accordingly, the court of appeals held that petitioner "must determine eligibility for medigap coverage as though the veterans had received care from a private billing hospital which participated in and received reimbursement through the Medicare program." Pet. App. 9a-10a.

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or any other court of appeals. Indeed, as the Eleventh Circuit observed, "[t]his decision brings Blue Cross/Blue Shield of Alabama in line with * * * the plans in 19 states and the District of Columbia [which] all provide for reimbursement to the United States under medigap policies. * * * The plans have consistently lost in litigation involving the claims of

the United States." Pet. App. 10a (citing *United States* v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993); *United States* v. *Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718 (4th Cir.), cert. denied, 114 S. Ct. 302 (1993)). Moreover, this Court recently declined to review the decision in *Blue Cross & Blue Shield of Maryland*, in which the Fourth Circuit rejected virtually the same arguments asserted by petitioner in this case. Review by this Court is therefore unwarranted.

At this stage, petitioner's sole contention (Pet. 5) is that, by holding that medigap policies are subject to the anti-discrimination provisions of 38 U.S.C. 1729, the court of appeals' decision imposes extra-contractual burdens on petitioner in violation of its Fifth Amendment right to contract.[6]

1. Petitioner first argues (Pet. 7) that because the "obligation to pay Medicare-derived costs is the

[6] Petitioner states (Pet. 6 n.1) that it "continues to contend before this Court that the C Plus policies are not 'health plan contracts' within the scope of 38 U.S.C. § 1729," but "for the sake of argument within this Petition, and without waiver of its remaining arguments before the lower courts," its arguments will focus "on the failure of Section 1729 to trigger liability under these policies even if they are considered to be included in the statutorily-defined third party payors." Rule 14.1(a) of the Rules of this Court provides, however, that "[o]nly the questions set forth in the petition, or fairly included therein, will be considered by the Court." The only question stated in the petition is: "Whether, in erroneously interpreting 38 U.S.C. § 1729, the courts below imposed extracontractual burdens upon Blue Cross by effectively changing the supplemental nature of the C Plus Medicare supplemental contracts in violation of Blue Cross's Fifth Amendment-protected right to contract?" Only that Fifth Amendment question is properly presented by the petition.

essence of the Medigap contract[,] * * * any requirement that Blue Cross pay for health services incurred outside the realm of the Medicare statutes in fact imposes a duty upon Blue Cross that was not contractually assumed when Blue Cross offered the C Plus contract." The Fourth Circuit in *Blue Cross & Blue Shield of Maryland* rejected a similar contention that "there is a federal statutory requirement that medigap policies operate necessarily and exclusively in tandem with Medicare payment," explaining that such an argument "confuses a person's entitlement to Medicare benefits with her actual ability to collect those benefits." 989 F.2d at 723. As the Fourth Circuit pointed out, the statutory provision precluding Medicare payments to VA hospitals is "a limitation to Medicare recovery but not to eligibility for the underlying benefits."[7] *Ibid.*

2. Petitioner next asserts (Pet. 10-12) that the medigap policies do not discriminate against the United States because the prerequisite of Medicare eligibility applies equally to private and public hospitals. Petitioner again confuses a patient's eligibility for Medicare reimbursement with the patient's actual ability to recover those benefits. Further, as the

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[7] The Fourth Circuit noted in *Blue Cross & Blue Shield of Maryland* that there are instances in which an individual might be eligible for Medicare, "yet still not receive reimbursement because she has not met a deductible, a coinsurance payment, or other limitation." 989 F.2d at 723. Further, there are instances in which a medigap policy will pay despite Medicare's failure to make reimbursement. *Id.* at 723-724 (citing examples). The court therefore concluded that payment under a medigap policy clearly "can be 'triggered' without payment of a Medicare benefit." *Id.* at 726.

court of appeals held, petitioner's participating hospital provision, "while not discriminatory in explicit terms, clearly operates 'to prevent recovery or collection by the United States.'" Pet. App. 8a. This is so because, "[w]hile the operation of this medigap provision would prevent recovery by VA hospitals, * * * it would almost always allow recovery to private hospitals." *Id.* at 8a-9a. Accord *Capital Blue Cross*, 992 F.2d at 1273 ("Congress' use of the word 'operate' manifests its intent not only to prohibit discrimination that appears o[n] the face of an agreement or a statute, but also discrimination that occurs in practice."). Such a result constitutes discrimination against the United States in violation of 38 U.S.C. 1729(f).

3. Petitioner finally argues (Pet. 12-14) that the court of appeals erred in holding that its right to contract was not constitutionally impaired, because the court mistakenly believed that enactment of 38 U.S.C. 1729 preceded issuance of the medigap policies. Petitioner asserts (Pet. 12-13) that "[i]n fact, Blue Cross wrote and issued the C Plus contract before Congress amended § 1729, effective April 7, 1986, to allow for payment under health plan contracts to the government."[8]

[8] Two sentences earlier, petitioner states (Pet. 12) that "the C Plus contracts issued between January 1, 1986 and 1990 were virtually unchanged" (footnote omitted). Whether or not contracts petitioner entered into with individual veterans after April 7, 1986 were "virtually unchanged" from (or indeed identical to) earlier contracts, there could be no contention that the Fifth Amendment would bar application of Section 1729 to such policies.

Even if BCBS wrote the medigap policies before Congress amended Section 1729, however, that Section applies to the policies if they were modified or renewed after the effective date of Section 1729's amendment. When Section 1729 was amended, Congress specifically addressed the amendment's application to pre-existing health plan contracts, and provided:

> In the case of a health-plan contract * * * that was entered into before [April 7, 1986] and which is modified or renewed on or after such date, the amendment * * * shall apply * * * with respect to care and services provided after such date of modification or renewal. * * * [T]he term 'modified' includes any change in premium or coverage.

Pub. L. No. 99-272, Tit. XIX, § 19013(b), 100 Stat. 385. Because petitioner did not address fully below any issues regarding the veterans' policies' effective dates, modifications or renewals, the record does not contain detailed information concerning those matters. See Pet. C.A. Br. 6-7; C.A. Record Excerpts. To the extent the record does address those concerns, however, it appears that the relevant policies were either entered into, modified or renewed following Section 1729's effective date.[9]

[9] Given common practices in the health insurance industry, it is virtually inconceivable that the policies were not renewed or the premiums altered before the veterans received the services at issue in this litigation. The record demonstrates that some of the applicable C Plus policies were entered into well after April 7, 1986, and suggests that the contracts were renewed on an annual basis each January 1. See C Plus with PMD, Medicare Supplemental Contract, Attachment 8 to Pl.'s Mot. for Summ. J. (noting effective date of January 1, 1988).

In any event, "[i]mmunity from federal regulation is not gained through forehanded contracts." *FHA* v. *The Darlington, Inc.*, 358 U.S. 84, 91 (1958) (citation and internal quotation marks omitted). Rather, "[s]o long as the Constitution authorizes the subsequently enacted legislation, the fact that its provisions limit or interfere with previously acquired rights does not condemn it." *Ibid.*[10] As the court of appeals noted, petitioner has not challenged the authority of Congress to "provide that the United States could not be discriminated against in the operation of such medical insurance plans." Pet. App. 9a.

~~renewed on an annual basis each January 1. See C Plus with PMD, Medicare Supplemental Contract, Attachment 8 to Pl.'s Mot. for Summ. J. (noting effective date of January 1, 1988).~~ The record also reflects, contrary to petitioner's suggestions (Pet. 12 & n.4), that the veterans received treatment at VA hospitals between mid-1987 and 1990. See Pet. App. 12a; C.A. Record Excerpts Tab 7, at 3-13 (Amended Complaint). Accordingly, the veterans' treatment most likely occurred during contracts effective after April 7, 1986 or following annual renewals or modifications of any policies BCBS wrote before April 7, 1986; in such circumstances, Section 1729, by its terms, unquestionably applies to the policies.

[10] As this Court explained in *Connolly* v. *Pension Benefit Guaranty Corp.*, 475 U.S. 211 (1986):

> Contracts, however express, cannot fetter the constitutional authority of Congress. Contracts may create rights of property, but when contracts deal with a subject matter which lies within the control of Congress, they have a congenital infirmity. Parties cannot remove their transactions from the reach of dominant constitutional power by making contracts about them.

Id. at 223-224 (quoting *Norman* v. *Baltimore & O.R.R.* 294 U.S. 240, 307-308 (1935)).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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